HOSPITAL FINANCING: THE IMPOSSIBLE AND THE POSSIBLE DREAMS*

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THE project upon which this paper is based in part was performed pursuant to a contract with the Health Care Financing Administration, Department of Health, Education, and Welfare.

Not long after Medicare was enacted in 1965 an increasing number of voices began to be heard saying, first, that the American health system was a shambles; second, that the method of financing health care was primarily responsible for creating this monster; and, third, that the right modification in financing would cure the system's ills. Proponents of some quite simple changes envision the early coming of a perfect system provided the changes they propose are adopted.

THE HEALTH-SYSTEM DREAM

They dream of a health-care system in which capacity is exactly in line with need and in which:

Technology is applied only when justified by cost-benefit considerations.

The surgery that is performed always cures the patient.

Fraud is nonexistent.

Each hospital provides only the services appropriate for it.

Patients adopt life styles that prevent illness.

Physicians know what all their prescriptions cost and act to reduce cost as well as to treat properly.

Every patient receives the best treatment available for his illness.

Every hospital performs at the peak of efficiency.

*Presented in a panel, Financing Hospital Care: Costs, Quality, and Utilization, as part of the 1978 Annual Health Conference of the New York Academy of Medicine, *The Hospital Reconsidered: A New Perspective,* held at the Academy May 1 and 2, 1978.

Physicians are so distributed by specialty and location as to give everyone equal and convenient access to care.

Every hospital is reimbursed commensurately with the needed services it provides.

The financial requirements for needed health facilities are fully met.

All payers share the burden of costs fairly.

Health costs rise little, if any, more than the Consumer Price Index.

Patients choose lower cost in preference to higher cost hospitals.

The regulation of health care is no longer needed because automatic economic market forces produce the required results.

A Few Simple Measures

Some proponents of change envision such wonderful results as these if that proponent's suggestions for one or two simple changes are adopted. The suggestions related to health costs fall into two classes: those that change the economic incentives in the health-services industry and those that directly control the prices of quantities of health services produced or of resources used. In the debate, the economic-incentive approach and the controls approach are frequently referred to as the nonregulatory and regulatory methods, but in fact economic-incentive methods often require regulations to make them operative, and regulatory devices often embody economic incentives to improve performance.

Making the Health Consumer an Economic Man

Some economists favor a plan based on the idea that health insurance is primarily responsible for the high cost of health care and associated difficulties, reasoning that when a patient pays little or nothing for his care, he demands too much and the system provides too much. The economic man, being a prudent buyer, would not demand such extravagance. One inducement to prudence is a suggested reduction in the amount of the patient's health insurance. Catastrophic financial consequences, despite the insurance reductions, would be avoided by placing a maximum of, say, 10% of income on a family's direct payments for health care. Above that sum, the insurance would pay total costs.

I am not convinced that patients will be motivated to select hospital care more appropriately by this device. Patients whose hospitalized illnesses cost above 10% of their annual income would have no more incentive than at present to choose from the low-cost end of the spectrum. With a

$15,000 annual family income and a 50% copayment, most families of four with one member in the hospital would reach $1,500 in out-of-pocket health copayment costs regardless of its choice of providers. Therefore, the plan's potential seems directed toward families without serious illness.

Second, it remains to be proved that a 50% copayment would make a great difference to patients in obtaining ambulatory care. Much, perhaps most, ambulatory care is paid for 100% by the patient today. If a patient pays only 50% of the market price for health services, he may believe that the half-price sale offers a bargain.

Third, patients are not very expert at selecting the most cost-effective care, nor is it always true that the lowest-cost care is the better buy. There is a pretty good possibility that Sloan-Kettering Memorial Hospital treats cancer extremely well and the difference in cost between cancer treatment there and that in many community hospitals is worthwhile. If patients are to choose wisely, they need information not now available to anyone on outcome successes by type of illness and provider as well as on the cost for treatment of specific conditions.

Fourth, an annual cost limit with zero out-of-pocket costs above it and the 50% co-payment below it favors high-cost over low-cost care and may actually expand high-technology services such as organ transplants and may very much increase nursing-home support.

Fifth, the plan is based on a means test in that more benefits are provided to those with lesser resources and many persons are philosophically opposed to such tests. Further, I think that even those who accept a means test will find that application of the test will not be entirely satisfactory. Income known with some precision when illness strikes may differ from current income, since illness may have terminated employment. Measured income will only roughly approximate a determination of resources, and if the income tax is relied upon as a data source, it will provide special advantages to those who benefit from loopholes. To measure income at the time of illness may involve considerable time lapse after treatment and during the interval the amount of benefits will be in doubt.

Sixth, the approach will probably require regulation not only of quality, but of price. Price regulation may be needed to at least avoid collusion between provider and patient on high charges with the understanding that the patient need not pay his nominal share in full. Government payment based on the posted price may be very handsome and require little if any patient supplementation to satisfy the provider. An alternative might re-

quire full payment by the patient of the share of the cost he is assumed to be responsible for. But this alternative would be both difficult to enforce and of doubtful acceptability. Regulation would also have to bar such supplementary insurance of the copayments as now occurs in the case of the relatively modest Medicare copayments.

Seventh, the proposal does not take into account that part of reimbursement is for educational costs. The patient receives no direct return for paying these costs. Education is a benefit to society in common but each individual is better off if others pay for it.

In sum, it seems unlikely that a plan based solely on patient incentives produced by out-of-pocket payments will prove satisfactory even though consumer payments to maintain concern about the cost of care will have a place in the health-care system.

Consumer Choice of Health Plans

Some economists favor a second plan to improve the choice of insurance mechanisms by requiring consumers to pay more of the insurance premium out-of-pocket. One step in this direction is to end employer payment of all or most of the cost of insurance. Changing the tax treatment of employer financing of health insurance and the tax deductibility of health-insurance premiums is part of this plan. The theory is that if people buy their health insurance carefully, selecting the kind that gives them the most for their money, they will stimulate development of the most effective insurance arrangements. Insurers, the theory goes, would purchase services through the most effective systems of delivering health care because they would have to compete for customers with health maintenance organizations and other effective organizations. Thus, the assumption is that market pressures would produce the desired results and regulation would not be needed. Eliminating regulation would reduce costs. To increase competitive effectiveness, special help might be given to assist the development of health maintenance organizations. I doubt that this plan would work. First, its success depends on consumer analysis of insurers and consumer determination of which insurer is most effective. It requires that the consumer know the right way to purchase care and to know whether the insurer follows the preferred course. Current experience provides no grounds for optimism that consumers would have or use such knowledge. Many consumers now purchase individual health insurance entirely out-of-pocket and retain all the savings they achieve by effective purchases, but there is

no indication that these consumers purchase their insurance very wisely.

Federal employees are offered a wide choice of plans whose costs to them vary considerably. There is no indication either of especially effective payment for care by the insurers under these conditions or that large numbers of federal employees have chosen the most effective plan available to them. In fact, there is no indication that federal employees have analyzed or are able to analyze the relative values of insurance plans offered. Nor does information provided to the employees include such appraisals.

Second, although group-practice prepayment plans seem to many health analysts to provide comparatively effective results, in most areas these plans have had considerable marketing problems. They seem unable to sell themselves widely. With no indication that this marketing problem is on its way to solution, the presumption of effective competition from efficient health maintenance organizations may be a mirage.

Third, some areas have an insufficient population density to support efficient alternative facilities, and for some services so small a capacity for care is needed that monopoly arrangements seem necessary to quality and efficiency. A single burn unit may be all that a very large area can afford, and monopoly generally has been assumed to require regulation.

Fourth, a plan has to begin at some point and at the start many subscribers' connections with the health-care system will require modification if they shift to health maintenance organization membership or to another system that obtains care from only part of the market. Many patients are reluctant to make such a shift.

Fifth, according to some data, many of those insured prefer insurance that minimizes need for comparison shopping for care and they are willing to pay for this extra service. For example, a health analyst at the University of Pennsylvania once demonstrated to his fellow faculty members that a low-option health-insurance plan available to them was a better buy than the most expensive higher option. Yet, overwhelmingly, after hearing the facts they chose the higher option to obtain the more complete coverage rather than the greater return for their payments. I believe that one reason for their choice was to reduce their problems in purchasing care.

While I conclude that consumer choice of insurance offers no panacea, this does not mean that the economists have no point when they emphasize the need to press third-party payors for more effective arrangements to pay for care. I believe there is need for the power of organized purchasers to

oppose the power of organized sellers. Organized purchasers can use informed judgment on what care is ineffective, inadequate, or overpriced and to refuse to pay for it. This power has been insufficiently used up to now and it should be brought into play.

Rate Controls

Other proponents of change believe in direct regulation of the industry, principally by prospective rate setting, service-planning controls, and peer review of services provided. The theory of rate control is that if the rate of hospital reimbursement is predetermined, the hospital is forced to make its operations more effective. By becoming more efficient, the hospital can live within its income. In other words, revenue controls force hospitals to find ways to perform at lower cost.

There are, however, limits to the extent to which rate regulation would lead us to the ideal system we are seeking. No methodology has been identified for establishing a payment rate that would stimulate optimum efficiency while maintaining quality and access to appropriate levels.

Second, and more important, the regulatory model requires the establishment of public policy on the ends that are sought. The market model presumes that the invisible hand of the market leads to the proper result. A regulatory program can be judged only by the degree to which it brings the intended policy into fruition. This policy should have both cost and service components; we have no such policy and little inclination to develop one.

A third problem with rate setting is that it deals only with very short-term issues, yet many current hospital costs were fixed by decisions made years ago as to services and facilities to be provided. To affect cost increases in 1985 we must carefully watch the decisions we are now making. Action in 1984 will be too late because once a service is approved, rates are certain to be set high enough to cover its costs.

Fourth, hospital rate setting principally affects hospital administrators and the matters they control, not physicians and their orders, and not the system to which the hospital must relate. Thus, rate regulation only very indirectly influences areas where many believe that the largest potential for productivity improvement exists.

I conclude that rate controls are unlikely to produce the desired changes in the health system. However, it seems that hospital rate-setting approaches that have efficiency-inducing effects can be developed.

HEALTH PLANNING

Health planning consists of controls on the availability of services and facilities on the theory that if capacity is controlled, both the nature and the costs of services provided can be predetermined within relatively narrow limits. Further, denying authority to build has seemed a more acceptable control measure than refusal to reimburse for services provided after construction is complete.

Planning has, however, thus far failed to live up to the hopes for it. First, planning legislation is written so that plans for the expansion of services are denied if the expansion is unnecessary, but very few projects proposed are totally without merit. The existing programs have given little attention to living within limited resources and of weighing the comparative merits of the various possibilities to select those that are most meritorious and fit within the affordable total. Second, planning consists of the very difficult process of foreseeing needs and resources years ahead of time and attempting to make capacity decisions to match them. The skills and knowledge of planners have not measured up to the task. Third, planning requires goals and the required goals have not been established. Fourth, in practice planning has proved almost totally ineffective in closing redundant facilities or services. Fifth, planning related to technology depends on cost-benefit data. Estimating cost effects is difficult, but measuring benefit values is almost impossible if the technology has some value. For example, we do not know how to value the extension of life for the disabled or the relief of pain. Perhaps we shall never solve such problems, but in the future we may know better whether new technology has any value at all and, if so, whether the value is greater than that of alternative approaches.

Sixth, difficult-to-resolve conflicts of interest seem to be inherent in the planning process. For one thing, what is best for a facility often conflicts with what is best for the health system, and lowering the cost of service in an area may conflict with increasing the amount of federal funding that may be obtained. While planning is not considered to have been very productive thus far, new concepts are being developed that may improve results. Limiting totals within which planners operate and grouping similar proposals more effectively to pick the most meritorious would stimulate competition among new projects. Further, there seems to be new interest in research to support sounder decision-making.

PEER REVIEW

Economists have offered previously discussed market models directed at the problem that, because consumers of medical care tend to be less inhibited by the price of services than other consumers, providers sometimes offer more care than is cost effective. Peer review aims at this same problem, reasoning that if physicians are responsible for preventing excessive use of services, they will do so because if they fail someone else will. If peer review reduces demand for services, both direct savings from the reduction and indirect savings from the reduced capacity needs in the future will follow.

So far, great effort has been expended on the format of peer review and relatively little on obtaining results. Results have been mediocre because:

1) The peer reviewers have found the threat of action in the case of ineffective performance unreal.

2) The peer-review system has demonstrated no commitment to elimination of services with a low return on the costs involved or to reducing the inter-regional differences in the frequency with which various services are provided.

3) The major emphasis of peer review has been on individual cases, not on patterns of practice.

4) Standards of practice often fail to be based on sound research.

5) There is no indication that, when undesirable patterns of practice are discovered, effective methods to change them are applied.

While I believe that peer review has not thus far documented its worth, there seems to be no alternate to reviewing whether services are provided appropriately. However, the review process clearly requires improvement.

THE COMPLICATED ANSWER

It should be no secret by now that I believe that no single simple reform will produce the health-care system we seek. This is not to say that we are helpless; indeed, some steps may have rapid and dramatic results. Financing requirements produced the quick desegregation of hospitals in 1966 as part of the steps to inaugurate Medicare. Important lessons can be learned from that successful step, including the selection of the time to take it, the full commitment of the president, the careful preparation to achieve acceptance by the Congress and other powers, and the effort to help those who legitimately seek to comply.

There are other elements to a successful reform strategy. We should seek to do no more than we are sure will be advantageous and not counterproductive over the long term. Very often we need to move incrementally. Regulations need to be applied with sensitivity and must often allow room for negotiation.

An example of successful action of the kind we need involves the recent closure of a hospital, made possible by responding to the legitimate problems of those affected—to the physician staff by providing them privileges elsewhere, to displaced employees by arranging job placements, and to the community by keeping open certain outpatient services under the direction of a successor institution. We need to consider all such parties as well as lenders and investors and to finance costs of closure if we are to have any success with such action. Legislative authority for punitive steps will prove empty if society does not allow their application because important groups are adversely affected. Further, government action perceived to fail to provide equitable treatment has a low probability of acceptance and, if accepted, has a short life expectancy. Equity must therefore play an important role in our strategy.

The wide acceptance required before services can be reduced or additions denied is more likely with community understanding of the issues and convincing research proof supporting the move. England has great power to regulate under its system. But Archibald Cochrane, a leading researcher, reported that regulation was not needed in England for physician acceptance of sound research findings, that a medical procedure should be rejected because it was ineffective. Similarly, the British have found that closing hospitals in their country has been possible only with community acquiescence. They have had the patience to take the time and make the effort to obtain such acquiescence.

In general, success with planning depends upon a public well informed about living within limited resources. The actions we take cannot be more stringent than the majority finds acceptable. Success with peer review depends, I believe, on modeling the process on industrial statistical quality control. We shall need to establish standards of proper practice, make the measurements needed to identify where practice departs significantly from the standard, i.e., is out of control, and bring the system under control.

We should provide financial and other devices to change the structure of health-system units so that there will be fewer conflicts between institutional and community interests. One such change would integrate medical

staffs into the administrative structure of hospitals to help diminish staff demands for excessive facilities. A further broader step consists of the operation of hospitals in a community as a consortium. In such a case community physicians could obtain access to facilities appropriate for their practices, and educational programs would draw upon multiple institutions. Incentives for duplication of services would decline.

We need to reassess our manpower development programs carefully because training physicians to produce more services than we can afford to pay for will be very wasteful. Prudent purchasing of services by patients and third-party payers, planning controls, rate regulation, and peer review probably all are needed, but more important will be the development of a sound long-range policy. We shall need strong will, great persistence, and patience to deal effectively with the obstacles we shall meet. That is the way we shall be able to change our dreams of a better system into realities.